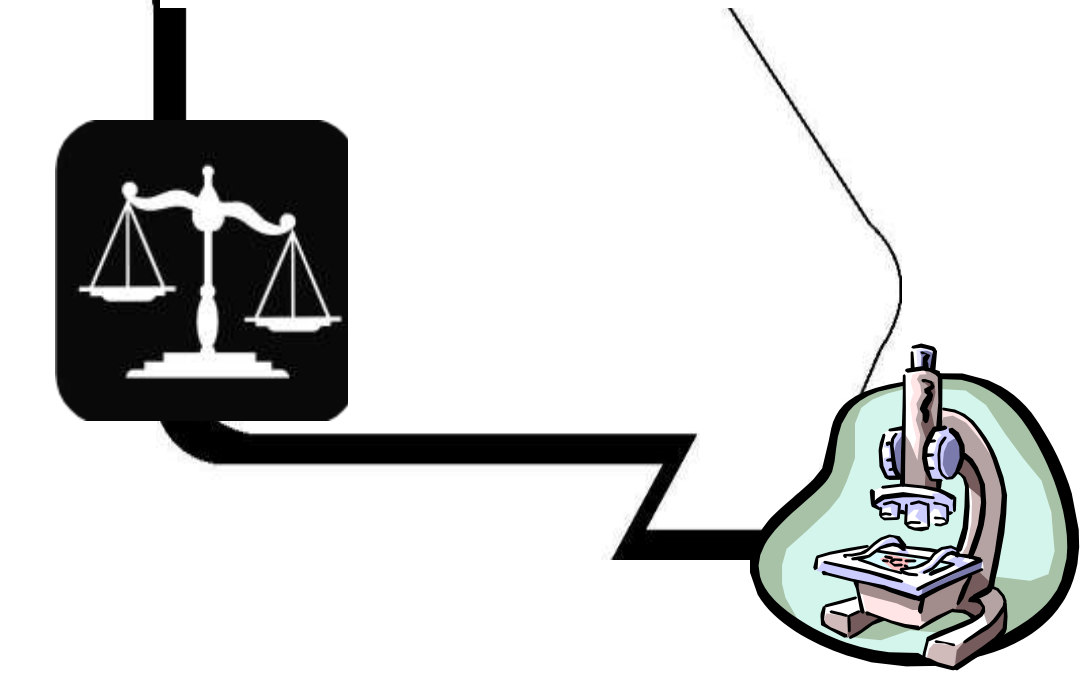
Court Force Handbook

MISSOURI HANDBOOK FOR OFFICERS OF THE COURT

Court Commitment of Tuberculosis Patients



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Introduction

Missouri statutes have been developed to meet the need for more comprehensive and specific TB control measures to:

- Help ensure that potentially infectious TB cases are made noninfectious as quickly as possible,
- Help ensure that TB cases complete a prescribed regimen, and
- Prevent the emergence and spread of multidrug-resistant TB (MDR-TB).

When infectious TB patients are not complying with treatment regimens or following other protocols (such as isolation) to ensure that they do not infect others, public health agencies must consider committing them to a facility that provides treatment. Committing an infectious TB patient to a treatment facility requires collaboration between courts and public health agencies to minimize the spread of TB. This collaboration assures TB cases are made non-infectious as quickly as possible.

This manual shows how the courts can assure the public's health by restricting movements of infectious persons. It contains sample documents that can be used during the commitment process, a fact sheet on tuberculosis for officers of the court and transporters of TB patients, definitions, as well as Missouri statues and regulations that pertain to TB.

SAMPLE DOCUMENTS AND THE COMMITMENT PROCESS

Sample forms and guidelines that can be used in the commitment process are provided in the handbook. The following outline describes the process and when to use the forms.

I. TB patient is identified.

The patient responsibility notification (9.2.1) is completed. The local public health agency (LPHA) initiates this notification when the patient is identified. At this time, the nurse informs the patient of their responsibility to adhere to the treatment plan. The nurse also informs the patient that they could be involuntarily committed to a facility designated by the Missouri Department of Health and Senior Services for treatment if they do not follow the plan.

II. TB patient is not complying with treatment plan.

If the patient does not comply with the treatment plan (not taking medications, not making appointments for directly observed therapy [DOT], not appearing for follow-up doctor's appointments, etc.) or if they are infectious and refuse to stay at home or wear a mask, the nurse informs the director of the LPHA who prepares and sends a warning letter (9.2.2) to the patient. All instances of noncompliance shall be documented and maintained in the patients chart.

III. TB patient still is not complying with the treatment plan.

If the patient is still not complying with the treatment plan or if an infectious patient is not complying with orders to stay at home and wear a mask when appropriate, the LPHA prepares an affidavit (9.2.3). The LPHA also notifies Department of Health and Senior Services (DHSS), which prepares the certification (9.2.4) for the nurse. The nurse collects all the available documentation of noncompliance. The evidentiary tuberculosis information sheet for attorneys (9.2.5) lists different types of appropriate evidence. The certification states that the records that are transferred from DHSS are bona fide records. The LPHA then contacts the prosecuting attorney and sends all of the documentation.

IV. The prosecuting attorney at this point should prepare the petition (9.2.6) to the court and present it to the court for a hearing date.

V. The petition is also used for 96-hour emergency commitment. Emergency commitment is utilized for a very contagious noncompliant individual while the court date for commitment is being scheduled.

Tuberculosis (TB) Patient Responsibilities Notification

I, _____(patient's name), understand I have been diagnosed with tuberculosis and that I have the following responsibilities in regards to my condition and treatment.

- That while infectious I must remain at home (including not working or attending school) so I will not spread TB bacteria to other people.
- If I must leave my home or I have guests into my home, I must wear the protective mask provided to me.
- That I will be placed on several different medications for the next several months and that this medication must be taken exactly as the doctor or nurse has instructed me to take it.
- That while on these medications I will be participating in Directly Observed Therapy (DOT) and must be available to the health care worker at the time and place we agreed upon to receive my medications.
- That while taking these medications I will report any serious side effects to my doctor or nurse. These side effects may include, but are not limited to, the following:

No Appetite	Tingling or Numbness Around the Mouth
Nausea	Easy Bruising
Vomiting	Blurred Vision
Yellowish Skin or Eyes	Ringing in the Ears
Fever for 3 or More Days	Hearing Loss
Abdominal Pain	Dizziness
Tingling fingers or toes	Aching Joints
Skin Rash	Easy Bleeding

- That I must keep all scheduled appointments.

I understand that my failure to comply with these responsibilities could result in prolonging my illness and pose a health risk to others as long as I remain infectious. By my signature below I certify that my responsibilities in regards to my treatment for tuberculosis and the consequences of not meeting my responsibilities have been explained to me and that I understand these responsibilities. I further certify that my failure to meet these responsibilities could result in my involuntary hospitalization pursuant to § 199.180 of the Missouri Revised Statues.

_____ _____

(Signature of Patient) (Date Signed)

_____ _____

(Witnessed By) (Date Signed)

I was present when the above was read to _____

_____ _____

(Witnessed By) (Date Signed)

(Date)

Name
Street
City, MO Zip

Dear Mr/Mrs/Ms. _____:

I have been informed by _____ (health care worker), in accordance with Section 192.067 of the Missouri Revised Statutes and 19 CSR 20-20.020, that you have been diagnosed as having tuberculosis disease as confirmed by _____. You were placed on notice on ___/___/___ (date) that you have been diagnosed with tuberculosis disease and were given notice of your responsibilities and obligations as a result, including the need to follow your prescribed treatment plan. You acknowledged on ___/___/___ (date), by signing the "Tuberculosis Patient Responsibilities Notification", that you understood your responsibilities and the importance of your compliance with these responsibilities and obligations.

You have indicated to _____ (health care worker), our records indicate that you are now unable/ unwilling to adhere to your prescribed treatment plan. As a result, you pose a risk to the public health of others. Continued failure/ refusal to comply with the prescribed course of treatment will result in you remaining in a continued infectious state, thereby exposing other persons to danger of infection.

This letter is to place you on notice that you must complete treatment as prescribed by your physician. If you continue to fail to comply with the prescribed treatment, then pursuant to Section 199.180 of the Missouri Revised Statutes, the Board of Public Health may file a Petition with the Circuit Court, seeking to have you committed to a specified facility, where you will remain confined for the period of your treatment.

This agency will continue to work with you and your physician to provide such assistance as is reasonably appropriate to facilitate the completion of your prescribed treatment plan. If you have any questions, please call (____) ___-____.

Dated at _____, Missouri on _____.

LPHA Director's Signature
Title
Town, Missouri

STATE OF MISSOURI)
) ss.
County of _____)

AFFIDAVIT

I, Florence Nightingale, of lawful age and being first duly sworn do hereby state the facts contained in the Affidavit are true to my best knowledge, information and belief.

That I am presently licensed as a (List license R.N., M.D. etc.) in the State of _____. As a part of my education, training and experience in the health care field, I have worked closely with patients who were treated for active tuberculosis. Additionally, I have _____ years experience in the area of treatment of persons with tuberculosis. I am currently employed at (list treatment facility/or department), located in (list city and county).

Amy Jones is a patient at the (list facility where the patient is being treated). Further during treatment and testing of Amy Jones, she was diagnosed as having active tuberculosis. The basis of the diagnosis of active tuberculosis was:

(Here list the relevant diagnosis information) Example:

1. An abnormal x-ray.
2. A positive smear report indicating acid-fast bacilli (AFB). Attached Exhibit
3. A culture report of the sputum of Amy Jones showing AFB was present. Attached as Exhibit 2.

During the treatment of Amy Jones, Ms Jones was advised of the responsibilities of a tuberculosis patient as evidenced by the Patient Responsibilities Notification form signed by Amy Jones on (list date), a copy of which is attached to this affidavit and incorporated herein by reference. Attached as Exhibit 3.

Further, Amy Jones has refused to follow the treatment plans as outlined for her by her treating physicians. By failing to follow the treatment plans, Amy Jones is creating a health risk to herself and the general population at large. Moreover, if Amy Jones is not ordered to follow a prescribed treatment plan (list here results of her failure to follow the plan and any other relevant information you may have to show why the court should issue its order).

_____
Florence Nightingale

On this_____ Day of _____in the year 20__ before me, Ima Friend (name of notary), a Notary Public in and for said state, personally appeared Florence Nightingale (name of individual), known to me to be the person who executed the within Affidavit, and acknowledged to me that she executed the same for the purposes therein stated.

_____
Ima Friend, Notary Public

(Notary Seal or Stamp)

STATE OF MISSOURI)
)ss
COUNTY OF COLE)

CERTIFICATION

Before me, the undersigned authority, personally appeared Harvey L. Marx, Jr., Chief of the Bureau of Communicable Disease Control and Prevention, Missouri Department of Health and Senior Services, who, being by me duly sworn and deposed, states as follows:

My name is Harvey L. Marx, Jr. I am of sound mind, capable of making this certification, and personally acquainted with the facts herein stated:

I am the custodian of records for the Bureau of Communicable Disease Control and Prevention, Missouri Department of Health and Senior Services. Attached hereto are records consisting of _____ pages which comprise reports relating to sputum examinations for _____. These records are kept by the Missouri Department of Health and Senior Services in the regular course of business, and it was the regular course of business of the Bureau of Communicable Disease Control and Prevention, Missouri Department of Health and Senior Services' representatives, with knowledge of the act or event recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time of the act or event. The records attached hereto are exact duplicates of the originals.

_____
Harvey L. Marx, Jr., Chief
Bureau of Communicable Disease Control and Prevention
Missouri Department of Health and Senior Services

In witness whereof I have hereunto subscribed my name and affixed my official seal this ___ day of _____, 2012.

_____
Notary Public

My commission expires:

EVIDENTIARY TUBERCULOSIS INFORMATION SHEET FOR ATTORNEYS

EVIDENCE OF CONTAGIOUSNESS

Smear Report

- The results from the smear will be available in about 24 hours after it reaches the laboratory.
- This is derived from a sample of sputum collected from the patient. This indicates that AFB (acid-fast bacilli) is present.
- There are many different kinds of AFB and Tuberculosis is one.
- TB is the only AFB that is contagious from person to person.
- Positive AFB smear reports will have a +1 (rare), +2 (few), +3 (moderate) or +4 (many) on them. With +4 indicating the highest degree of contagiousness.
- After the patient has been on treatment for a couple of weeks the numbers on the AFB smear reports should begin to decrease until there is no AFB present.

Culture Report

- This is the final report on the sputum and may take from 2 to 8 weeks to get the results.
- It identifies which AFBs are present.
- Tuberculosis culture reports that have tuberculosis identified are said to be positive. Culture reports that do not identify tuberculosis are said to be negative.
- It is the gold standard used to diagnosis Tuberculosis.
- A person with tuberculosis receiving adequate treatment should have negative culture reports within one to three months after treatment is started.

Sensitivity Report

- Medications used to treat patients are tested to see if these particular TB germs can be eliminated with these medicines.
- If the germs can be eliminated using the medication listed, it will say TB germs are sensitive to each medication.
- If the germs cannot be eliminated by using these medications, the report will say they are resistant to the medication.

Chest X-ray Report

- Most people who have active TB will have abnormal chest x-ray findings, but not always.
- Most abnormal findings will be in the upper lobes of the lungs, but not always.
- The chest x-ray should improve after the patient has been on an adequate treatment regimen and taking medication as prescribed.

Documented Skin Test Conversions Among Contacts

- Contacts are people who have spent a significant amount of time with the person with TB.
- Contacts that have a positive (> 5mm) TST (tuberculin skin test) reaction or a positive Interferon-Gamma Release Assay are said to have a skin test conversion.
- Skin test conversion on contacts indicates that the person with TB is contagious and is infecting others with TB.

Physical Exam

- If the doctor suspects the person has TB he often will write "suspected TB" and list reasons for this suspected diagnosis. Example: Patient is experiencing night sweats, has lost 30 pounds in two months, low grade fever and has a productive cough for 2 months, and his wife had active Tuberculosis about 5 years ago. He has a positive TST.

EVIDENCE OF NON-COMPLIANCE OR POTENTIAL FOR NON-COMPLIANCE

Missed Clinic Appointments

- Indicates that patient is not following up as instructed and there may be a multitude of reasons for this.

Missed Medication Dosages

- This is really important because TB germs can rapidly become resistant to the medications treating TB if they are not adhered to exactly as prescribed.

Psychosocial Concerns:

- Homelessness- if the person has no home they may wander from place to place increasing the number of people they infect. The nurse may not be able to locate the patient to give the medication, thus increasing chances of missed doses and prolonging time of contagiousness.
- Alcoholism – When alcohol is consumed while taking TB medications it increases the potential for liver damage. When liver dysfunction occurs it makes treating TB extremely difficult.
- If a person is inebriated (drunk) it also increases the likelihood of not taking the medicine as prescribed.
- If a person is inebriated it also increases the risk that isolation from other people will not be maintained and the person will not use precautions such as wearing a mask or covering their mouth when coughing, etc.

EVIDENCE OF PROBLEMS MAINTAINING ISOLATION

- Homelessness – the person will not have a place to stay away from other people. Also, the person may not be able to stay warm or cool or dry thus increasing the possibility of developing other illnesses.

Young Children in Home

- Young children who become infected with TB germs have a much higher risk of rapidly developing TB disease and often develop TB meningitis.

EVIDENCE OF EDUCATION PROVIDED TO PATIENT

- Medication information including dosages.
- Information on infectiousness and the importance of isolation.
- Potential for drug resistance if medications are not taken as prescribed.
- This information should be kept in the patient's medical record at the local health department. This is a record showing that the patient has been informed of their responsibilities and what they can expect if these instructions aren't followed.

PETITION

IN THE CIRCUIT COURT OF _____, COUNTY
STATE OF MISSOURI

_____COUNTY)
PUBLIC HEALTH DEPARTMENT,)
Petitioner) Case No. _____
v.)
_____)
Respondent.)

PETITION FOR COMMITMENT

Petitioner the _____County Public Health Department, by and through its attorney _____, states and alleges as follows:

1. Respondent __(individual)___ , a _____ male/female, age ____, is a person with active tuberculosis, as demonstrated by the following clinical, bacteriological or radiological evidence:_____.(or is a person who is a potential transmitter of tuberculosis, in that he/she has the diagnosis of pulmonary tuberculosis as of __(date/ place of diagnosis)__, but has not begun a recommended course of therapy, or having begun a recommended course of therapy, has not completed the therapy.)

2. Respondent is conducting himself/herself in such a manner as to expose other persons to danger of infection, in that respondent is violating the rules, regulations, instructions or orders promulgated by the Department of Health and Senior Services or this Board of Public Health by: __(set forth ways in which respondent is violating rules, etc.)_____.

3. Respondent has been previously directed by this Board of Public Health to comply with such rules, regulations, instructions or orders, but respondent has refused and continues to refuse to so comply.

4. (Set forth any other relevant facts or special circumstances here.)

5. Respondent resides at _____, in _____County, Missouri. (or Respondent is a nonresident or has no fixed place of abode, but may be found at _____ in _____County.)

6. Section 199.180 of the Revised Missouri Statutes provides that when a person with active tuberculosis (or a person who is a potential transmitter) violates the rules, regulations, instructions, or orders promulgated by the department of health and senior services or the local board, and is thereby conducting himself or herself so as to expose other persons to danger of infection, after having been directed by the local board to comply with such rules, regulations, instructions or orders, the local board may institute proceedings by petition for commitment in the circuit court of the county in which such person resides, or if a nonresident or has not fixed place of abode, where such person may be found.

7. Public health requires the commitment of respondent so that he/she is no longer a risk to himself/herself or other members of the public.

8. Due to the public health risk, petitioner also asks this Court to order that respondent be ordered to wear a mask during all times that respondent is being transported by public transportation, such as a taxi, or by police, to the place of commitment.

Wherefore, Petitioner _____Board of Public Health prays this Court for its Order committing respondent _____ to a facility designated by the Missouri Department of Health and Senior Services until such time as the patient's discharge will not

endanger public health, in accordance with Section 199.230 of the Missouri Revised Statutes, further ordering that respondent be required to wear a mask during any times in which respondent is being transported by public vehicle or by the police to the place of commitment, and for such other relief as this Court deems just and proper.

Respectfully submitted,

_____
Attorney for Petitioner
(Address)

Verification of Health Care Provider

State of Missouri)
) ss.
County of _____)

The undersigned, being duly sworn on his/her oath, states that he/she is a health care provider licensed in the State of Missouri; that he/she has reviewed the foregoing Petition for Commitment, and is familiar with the facts of this matter; and that the statements and matters alleged in the Petition for Commitment are true to the best of his/her knowledge and belief.

_____
Name Date

Subscribed and sworn to before me this ____ day of _____, 20__.

_____
Notary Public My commission expires:

DEFINITIONS OF TERMS IN THIS GUIDE

Active Tuberculosis - tuberculosis disease that is demonstrated to be contagious by clinical, bacteriological, or radiological evidence. Tuberculosis is considered active until cured.

Cavity - a hole in the lung resulting from the destruction of pulmonary tissue by TB or other pulmonary infections or conditions. TB patients who have cavities in their lungs are referred to as having cavitary disease and they are often more infectious than TB patients without cavitary disease.

Culture - the process of growing bacteria in the laboratory so that organisms can be identified.

Cure/Treatment To Cure - the completion of a recommended course of therapy as defined in subdivision (5) of this section and as determined by the attending physician.

Directly Observed Therapy (DOT), - an adherence-enhancing strategy in which a health care worker or other designated person watches the patient swallows each dose of medication.

Interferon-Gamma Release Assays (IGRAs) are whole-blood tests that can aid in diagnosing *Mycobacterium tuberculosis* infection.

Tuberculin Skin Test (TST) is the standard method in aiding in the diagnosis of *Mycobacterium tuberculosis*. The TB skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm.

Latent TB Infection - a condition in which living tubercle bacilli are present in the body but the disease is not active. Infected persons usually have positive tuberculin reactions, but they have no symptoms related to the infection and are not infectious. However, infected persons remain at lifelong risk of developing disease unless preventive therapy is given.

Local Board - any legally constituted local city or county board of health or health center board of trustees or the director of health of the city of Kansas City, the director of the Springfield-Greene County health department, the director of health of St. Louis County or the commissioner of health of the City of St. Louis, or in the absence of such board, the county commission or the county board of tuberculosis hospital commissioners of any county.

N95 - a personal respiratory protection mask that does not allow for tuberculosis bacteria to enter from the patient into the atmosphere.

Potential Transmitter - any person who has the diagnosis of pulmonary tuberculosis but has not begun a recommended course of therapy, or who has the diagnosis of pulmonary tuberculosis and has started a recommended course of therapy but has not completed the therapy. This status applies to any individual with tuberculosis, regardless of his or her current bacteriologic status.

Recommended Course of Therapy - a regimen of anti-tuberculosis chemotherapy that is in accordance with medical standards of the American Thoracic Society and the Centers for Disease Control and Prevention.

Smear - a laboratory technique for visualizing mycobacteria. The specimen is smeared onto a slide and stained, then examined using a microscope.

Sputum - phlegm coughed up from deep within the lungs.

Missouri Revised Statutes
Chapter 192
Department of Health and Senior Services
Section *192.005*

August 28, 2011

Department of health and senior services created--division of health abolished--duties.

192.005. There is hereby created and established as a department of state government the "Department of Health and Senior Services". The department of health and senior services shall supervise and manage all public health functions and programs. The department shall be governed by the provisions of the Omnibus State Reorganization Act of 1974, Appendix B, RSMo, unless otherwise provided in sections 192.005 to 192.014. The division of health of the department of social services, chapter 191, this chapter, and others, including, but not limited to, such agencies and functions as the state health planning and development agency, the crippled children's service*, chapter 201, the bureau and the program for the prevention of developmental disability, the hospital subsidy program, chapter 189, the state board of health, section 191.400, the student loan program, sections 191.500 to 191.550, the family practice residency program, the licensure and certification of hospitals, chapter 197, the Missouri chest hospital, sections 199.010 to 199.070**, are hereby transferred to the department of health and senior services by a type I transfer, and the state cancer center and cancer commission, chapter 200, is hereby transferred to the department of health and senior services by a type III transfer as such transfers are defined in section 1 of the Omnibus State Reorganization Act of 1974, Appendix B, RSMo Supp. 1984. The provisions of section 1 of the Omnibus State Reorganization Act of 1974, Appendix B, RSMo Supp. 1984, relating to the manner and procedures for transfers of state agencies shall apply to the transfers provided in this section. The division of health of the department of social services is abolished.

(L. 1985 S.B. 25 § 1, A.L. 1993 S.B. 52, A.L. 2011 H.B. 555 merged with H.B. 648)

*Section 201.020 as amended in H.B. 1270, 2010, changed the name to the "Children's Special Health Care Needs Service".

**Section 199.070 was repealed by S.B. 19, 1985.

Missouri Revised Statutes
Chapter 192
Department of Health and Senior Services
Section *192.067*

August 28, 2011

Patients' medical records, department may receive information from--purpose--confidentiality--immunity for persons releasing records, exception--penalty--costs, how paid.

192.067. 1. The department of health and senior services, for purposes of conducting epidemiological studies to be used in promoting and safeguarding the health of the citizens of Missouri under the authority of this chapter is authorized to receive information from patient medical records. The provisions of this section shall also apply to the collection, analysis, and disclosure of nosocomial infection data from patient records collected pursuant to section 192.667.

2. The department shall maintain the confidentiality of all medical record information abstracted by or reported to the department. Medical information secured pursuant to the provisions of subsection 1 of this section may be released by the department only in a statistical aggregate form that precludes and prevents the identification of patient, physician, or medical facility except that medical information may be shared with other public health authorities and coinvestigators of a health study if they abide by the same confidentiality restrictions required of the department of health and senior services and except as otherwise authorized by the provisions of sections 192.665 to 192.667. The department of health and senior services, public health authorities and coinvestigators shall use the information collected only for the purposes provided for in this section and section 192.667.

3. No individual or organization providing information to the department in accordance with this section shall be deemed to be or be held liable, either civilly or criminally, for divulging confidential information unless such individual organization acted in bad faith or with malicious purpose.

4. The department of health and senior services is authorized to reimburse medical care facilities, within the limits of appropriations made for that purpose, for the costs associated with abstracting data for special studies.

5. Any department of health and senior services employee, public health authority or coinvestigator of a study who knowingly releases information which violates the provisions of this section shall be guilty of a class A misdemeanor and, upon conviction, shall be punished as provided by law.

(L. 1988 H.B. 1134 § 3, A.L. 2004 S.B. 1279)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.170*

August 28, 2011

Definitions.

199.170. The following terms, as used in sections 199.170 to 199.270, mean:

(1) "Active tuberculosis", tuberculosis disease that is demonstrated to be contagious by clinical, bacteriological, or radiological evidence. Tuberculosis is considered active until cured;

(2) "Cure" or "treatment to cure", the completion of a recommended course of therapy as defined in subdivision (5) of this section and as determined by the attending physician;

(3) "Local board", any legally constituted local city or county board of health or health center board of trustees or the director of health of the city of Kansas City, the director of the Springfield-Greene County health department, the director of health of St. Louis County or the commissioner of health of the City of St. Louis, or in the absence of such board, the county commission or the county board of tuberculosis hospital commissioners of any county;

(4) "Potential transmitter", any person who has the diagnosis of pulmonary tuberculosis but has not begun a recommended course of therapy, or who has the diagnosis of pulmonary tuberculosis and has started a recommended course of therapy but has not completed the therapy. This status applies to any individual with tuberculosis, regardless of his or her current bacteriologic status;

(5) "Recommended course of therapy", a regimen of antituberculosis chemotherapy in accordance with medical standards of the American Thoracic Society and the Centers for Disease Control and Prevention.

(L. 1961 p. 518 § 1, A.L. 1986 H.B. 1554 Revision, A.L. 1990 H.B. 1739 merged with S.B. 742, A.L. 1999 H.B. 721 merged with S.B. 261, A.L. 2001 S.B. 266)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.180*

August 28, 2011

Local health agency may institute proceedings for commitment--emergency temporary commitment permitted, when.

199.180. 1. A person found to have tuberculosis shall follow the instructions of the local board, shall obtain the required treatment, and shall minimize the risk of infecting others with tuberculosis.

2. When a person with active tuberculosis, or a person who is a potential transmitter, violates the rules, regulations, instructions, or orders promulgated by the department of health and senior services or the local board, and is thereby conducting himself or herself so as to expose other persons to danger of infection, after having been directed by the local board to comply with such rules, regulations, instructions, or orders, the local board may institute proceedings by petition for commitment, returnable to the circuit court of the county in which such person resides, or if the person be a nonresident or has no fixed place of abode, then in the county in which the person is found. Strictness of pleading shall not be required and a general allegation that the public health requires commitment of the person named therein shall be sufficient.

3. If the board determines that a person with active tuberculosis, or a person who is a potential transmitter, poses an immediate threat by conducting himself or herself so as to expose other persons to an immediate danger of infection, the board may file an ex parte petition for emergency temporary commitment pursuant to subsection 5 of section 199.200.

(L. 1961 p. 518 § 2, A.L. 1990 H.B. 1739 merged with S.B. 742, A.L. 1999 H.B. 721 merged with S.B. 261, A.L. 2001 S.B. 266)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.190*

August 28, 2011

Patients not to be committed, when.

199.190. No potential transmitter who in his home or other place obeys the rules and regulations of the department of health and senior services for the control of tuberculosis or who voluntarily accepts care in a tuberculosis institution, sanatorium, hospital, his home, or other place and obeys the rules and regulations of the department of health and senior services for the control of contagious tuberculosis shall be committed under the provisions of sections 199.170 to 199.270.

(L. 1961 p. 518 § 8, A.L. 1990 H.B. 1739 merged with S.B. 742)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.200*

August 28, 2011

Procedure in circuit court--duties of local prosecuting officers--costs--emergency temporary commitment, procedures.

199.200. 1. Upon filing of the petition, the court shall set the matter down for a hearing either during term time or in vacation, which time shall be not less than five days nor more than fifteen days subsequent to filing. A copy of the petition together with summons stating the time and place of hearing shall be served upon the person three days or more prior to the time set for the hearing. Any X-ray picture and report of any written report relating to sputum examinations certified by the department of health and senior services or local board shall be admissible in evidence without the necessity of the personal testimony of the person or persons making the examination and report.

2. The prosecuting attorney or the city attorney shall act as legal counsel for their respective local boards in this proceeding and such authority is hereby granted. The court shall appoint legal counsel for the individual named in the petition if requested to do so if such individual is unable to employ counsel.

3. All court costs incurred in proceedings under sections 199.170 to 199.270, including examinations required by order of the court but excluding examinations procured by the person named in the petition, shall be borne by the county in which the proceedings are brought.

4. Summons shall be served by the sheriff of the county in which proceedings under sections 199.170 to 199.270 are initiated and return thereof shall be made as in other civil cases.

5. Upon the filing of an ex parte petition for emergency temporary commitment pursuant to subsection 3 of section 199.180, the court shall hear the matter within ninety-six hours of such filing. The local board shall have the authority to detain the individual named in the petition pending the court's ruling on the ex parte petition for emergency temporary commitment. If the petition is granted, the individual named in the petition shall be confined in a facility designated by the department of health and senior services in accordance with section 199.230 until a full hearing pursuant to subsections 1 to 4 of this section is held.

(L. 1961 p. 518 § 3, A.L. 2001 S.B. 266, A.L. 2010 S.B. 1007)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.210*

August 28, 2011

Rights of patient, witnesses--order of court--transportation costs.

199.210. 1. Upon the hearing set in the order, the individual named in the order shall have a right to be represented by counsel, to confront and cross-examine witnesses against him, and to have compulsory process for the securing of witnesses and evidence in his own behalf. The court may in its discretion call and examine witnesses and secure the production of evidence in addition to that adduced by the parties; such additional witnesses being subject to cross-examination by either or both parties.

2. Upon a consideration of the petition and evidence, if the court finds that the person named in the petition is a potential transmitter and conducts himself so as to be a danger to the public health, an order shall be issued committing the individual named in the petition to a facility designated by the department of health and senior services and directing the sheriff to take him into custody and deliver him to the facility. If the court does not so find, the petition shall be dismissed. The cost of transporting the person to the facility designated by the department of health and senior services shall be paid out of general county funds.

(L. 1961 p. 518 § 4, A.L. 1971 H.B. 581, A.L. 1985 S.B. 19, A.L. 1990 H.B. 1739 merged with S.B. 742, A.L. 1996 S.B. 540, A.L. 2010 S.B. 1007)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.220*

August 28, 2011

Order appealable.

199.220. The order shall be subject to review at the instance of either party, as in other civil cases.

(L. 1961 p. 518 § 5)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.230*

August 28, 2011

Confinement on order, duration.

199.230. Upon commitment, the patient shall be confined in a facility designated by the department of health and senior services until such time as the patient's discharge will not endanger public health.

(L. 1961 p. 518 § 6, A.L. 1971 H.B. 581, A.L. 1985 S.B. 19, A.L. 1996 S.B. 540, A.L. 1999 H.B. 721 merged with S.B. 261, A.L. 2010 S.B. 1007)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.240*

August 28, 2011

Consent required for medical or surgical treatment.

199.240. No person committed to a facility designated by the department of health and senior services under sections 199.170 to 199.270 shall be required to submit to medical or surgical treatment without his consent, or, if incapacitated, without the consent of his legal guardian, or, if a minor, without the consent of a parent or next of kin.

(L. 1961 p. 518 § 9, A.L. 1971 H.B. 581, A.L. 1983 S.B. 44 & 45, A.L. 1985 S.B. 19, A.L. 1996 S.B. 540, A.L. 2010 S.B. 1007)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.250*

August 28, 2011

Facilities, contracts with, costs, how paid.

199.250. 1. The department of health and senior services may contract for such facilities at the Missouri rehabilitation center as are necessary to carry out the functions of sections 199.010 to 199.350. Such contracts shall be exempt from the competitive bidding requirements of chapter 34.

2. State payment shall be available for the treatment and care of individuals committed under section 199.210 only after benefits from all third-party payers have been exhausted.

(L. 1961 p. 518 §§ 10, 11, A.L. 1971 H.B. 581, A.L. 1985 S.B. 19, A.L. 1991 H.B. 218 merged with S.B. 125 & 341, A.L. 1996 S.B. 540, A.L. 2010 S.B. 1007)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.260*

August 28, 2011

Apprehension and return of patient leaving rehabilitation center without discharge.

199.260. Any person committed under the provisions of sections 199.170 to 199.270 who leaves the facility designated by the department of health and senior services without having been discharged by the director of the facility or other officer in charge or by order of court shall be taken into custody and returned thereto by the sheriff of any county where such person may be found, upon an affidavit being filed with the sheriff by the director of the facility, or duly authorized officer in charge thereof, to which the person had been committed.

(L. 1961 p. 518 § 12, A.L. 1971 H.B. 581, A.L. 1985 S.B. 19, A.L. 1996 S.B. 540, A.L. 2010 S.B. 1007)

Missouri Revised Statutes
Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.270*

August 28, 2011

Proceedings for release of patient.

199.270. Any time after commitment, the patient or any friend or relative having reason to believe that such patient no longer has contagious tuberculosis or that his discharge will not endanger public health, may institute proceedings by petition, in the circuit court of the county wherein the confinement exists, whereupon the court shall set the matter down for a hearing before him within fifteen days requiring the person or persons to whose care the patient was committed to show cause on a day certain why the patient should not be released. The court shall also require that the patient be allowed the right to be examined prior to the hearing by a licensed physician of his own choice, if so desired, and at his own personal expense. Thereafter all proceedings shall be conducted the same as on the proceedings for commitment with the right of appeal by either party as herein provided; provided, however, such petition for discharge shall not be brought or renewed oftener than once every six months.

(L. 1961 p. 518 § 7)

Missouri Revised Statutes

Chapter 199
Rehabilitation Center--Head Injury--Tuberculosis Testing and Section *199.350*

August 28, 2011

Nursing homes and correctional centers, authority to promulgate rules for testing.

199.350. The department shall have the authority to promulgate rules and regulations which require the preadmission testing for tuberculosis of all residents in nursing homes in the state and the annual testing of all health care workers and volunteers in nursing homes in the state, and residents and staff of state correctional centers. The department shall annually issue screening guidelines on other groups determined by the department to be at high risk for tuberculosis.

(L. 1992 S.B. 511 & 556 § 2)

*Transferred 1994; formerly 198.041

Rules of Department of Health and Senior Services

Division 20—Division of Community and Public Health

Chapter 20—Communicable Diseases

***See Highlighted Regulations*

Title **Page**

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 20—Division of Community and Public Health
Chapter 20—Communicable Diseases

19 CSR 20-20.010 Definitions Relating to Communicable, Environmental and Occupational Diseases

PURPOSE: This rule defines terminology used throughout this chapter and defines terms related to infectious waste.

(1) Administrator is the person in charge of an institution, such as the chief executive officer, chairperson of the board, administrator, clinician in charge, or any equivalent position.

(2) Adult respiratory distress syndrome (ARDS) is a syndrome with the following simultaneous characteristics:

(A) Hypoxemia due to intrapulmonary shunting of blood;

(B) Increased lung stiffness; and

(C) Chest x ray evidencing diffuse infiltration.

(3) Board is the State Board of Health.

(4) Carrier is a person who harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source or reservoir of infection for man.

(5) Case, as distinct from a carrier, is a person in whose tissues the etiologic agent of a communicable disease is present and which usually produces signs or symptoms of disease. Evidence of the presence of a communicable disease also may be revealed by routine laboratory findings.

(6) Cluster is a group of individuals who manifest the same or similar signs and symptoms of disease.

(7) Communicable disease is an illness due to an infectious agent or its toxic products and transmitted, directly or indirectly, to a susceptible host from an infected person, animal or arthropod, or through the agency of an intermediate host or a vector, or through the inanimate environment.

(8) Contact is a person or animal that has been in association with an infected person or animal and through that association has had the opportunity to acquire the infection.

(9) Designated representative is any person or group of persons appointed by the director of the Department of Health and Senior Services to act on behalf of the director or the State Board of Health.

(10) Director is the state Department of Health and Senior Services director.

(11) Disinfection is the killing of pathogenic agents outside the body by chemical or physical means, directly applied.

(A) Concurrent disinfection is disinfection immediately after the discharge of infectious material from the body of an infected person or after the soiling of articles with the infectious discharges.

(B) Terminal disinfection is the process of rendering the personal clothing and immediate physical environment of a patient free from the possibility of conveying the infection to others after the patient has left the premises or after the patient has ceased to be a source of infection or after isolation practices have been discontinued.

(12) Environmental and occupational diseases are illnesses or adverse human health effects resulting from exposure to a chemical, radiological or physical agent.

(13) Exposure is defined as contact with, absorption, ingestion or inhalation of chemical, biologic, radiologic, or other physical agents by a human that results in biochemical, physiological or histological changes.

(14) Food is any raw, cooked or processed edible substance, ice, beverage or ingredient used or intended for use in whole or in part for human consumption.

(15) Heat exhaustion means a reaction to excessive heat marked by prostration, weakness and collapse resulting from dehydration.

(16) Heat stroke means a severe illness caused by exposure to excessively high temperatures and characterized by severe headache; high fever with a dry, hot skin; tachycardia; and in serious cases, collapse, coma or death.

(17) Hyperthermia means a physician-diagnosed case of heat exhaustion or heat stroke.

(18) Hypothermia means a physician-diagnosed case of cold injury associated with a fall of body temperature to less than ninety-four and one-tenth degrees Fahrenheit (94.1°F) and resulting from exposure to a cold environment.

(19) Immediately reportable diseases are those diseases or findings listed in 19 CSR 20-20.020(1)(A)–(C) and shall be reported at once, without delay and with a sense of urgency by means of rapid communication to the Missouri Department of Health and Senior Services or to the local public health agency, regardless of the day or hour.

(20) Immunization is a treatment which renders an individual less susceptible to the pathologic effects of a disease or provides a measure of protection against the disease.

(21) Infectious waste is waste capable of producing an infectious disease. For a waste to be infectious, it must contain pathogens with sufficient virulence and quantity so that exposure to the waste by a susceptible host could result in an infectious disease. Infectious waste generated by small quantity generators shall include the following categories:

(A) Sharps—all discarded sharps including hypodermic needles, syringes and scalpel blades. Broken glass or other sharp items that have come in contact with material defined as infectious are included;

(B) Cultures and stocks of infectious agents and associated biologicals—included in this category are all cultures and stocks of infectious organisms as well as culture dishes and devices used to transfer, inoculate and mix cultures; and

(C) Other wastes—those wastes designated by the medical authority responsible (physician, podiatrist, dentist, veterinarian) for the care of the patient which may be capable of producing an infectious disease.

(22) Institution is any public or private hospital, nursing home, clinic, mental health facility, home health agency, or medical or professional corporation composed of health care workers.

(23) Invasive disease is caused by a pathogen that invades the bloodstream and/or normally sterile bodily fluids and has the potential to cause severe morbidity and/or mortality. Culturing organisms from blood, cerebrospinal fluid, joint fluid, or pleural fluid identifies invasive diseases. Examples of conditions caused by invasive organisms include:

(A) *Haemophilus influenzae*—meningitis, occult febrile bacteremia, epiglottitis, septic arthritis, pericarditis, abscesses, empyema, and osteomyelitis;

(B) *Streptococcus pneumoniae*—bacteremia, and meningitis;

(C) *Neisseria meningitidis*—meningitis with or without meningococcemia, septicemia (purpura fulminans), bacteremia, pericarditis, myocarditis, arthritis, and epididymitis;

(D) *Streptococcus pyogenes* (group A)—bacteremia associated with cutaneous infection, deep soft tissue infection (necrotizing fasciitis), meningitis, peritonitis, osteomyelitis, septic arthritis, postpartum sepsis, neonatal sepsis, and non-focal bacteremia.

(24) Isolation is the separation for the period of communicability of infected individuals and animals from other individuals and animals, in places and under conditions as will prevent the direct or indirect transmission of the infectious agent from infected individuals or animals to other individuals or animals who are susceptible or who may spread the agent to others.

(25) Laboratory means a facility for the biological, microbiological, serological, chemical, immuno-hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of a human. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories. Laboratory includes hand-held testing equipment. All testing laboratories must be certified under the Clinical Laboratories Improvement Amendment of 1988 (CLIA—42 CFR part 493).

(26) Local health authority is the city or county health officer, director of an organized health department or of a local board of health within a given jurisdiction. In those counties where a local health authority does not exist, the health officer or administrator of the Department of Health and Senior Services district in which the county is located shall serve as a local health authority.

(27) Local public health agency is a legally constituted body provided by a city, county or group of counties to protect the public health of the city, county or group of counties.

(28) Methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE), and nosocomial infection are:

(A) MRSA shall be defined as S. aureus strains that are resistant to oxacillin, nafcillin and methicillin; historically termed MRSA. These organisms are resistant to all β-lactam agents, including cephalosporins and carbapenems. (NOTE: MRSA isolates are often resistant to other multiple, commonly used classes of antimicrobial agents, including erythromycin, clindamycin, and tetracycline.)

(B) VRE shall be defined as enterococci that possess intrinsic or acquired resistance to vancomycin. Several genes, including *van*A, *van*B, *van*C, *van*D, and *van*E, contribute to resistance to vancomycin in enterococci.

(C) Nosocomial infection shall be defined by the national Centers for Disease Control and Prevention and applied to infections within hospitals, ambulatory surgical centers, and other facilities.

(29) Outbreak or epidemic is the occurrence in a community or region of an illness(es) similar in nature, clearly in excess of normal expectancy and derived from a common or a propagated source.

(30) Period of communicability is the period of time during which an etiologic agent may be transferred, directly or indirectly, from an infected person to another person or from an infected animal to a person.

(31) Person is any individual, partnership, corporation, association, institution, city, county, other political subdivision authority, state agency or institution or federal agency or institution.

(32) Pesticide poisoning means human disturbance of function, damage to structure or illness which results from the inhalation, absorption or ingestion of any pesticide.

(33) Poisoning means injury, illness or death caused by chemical means.

(34) Quarantine is a period of detention for persons or animals that may have been exposed to a reportable disease. The period of time will not be longer than the longest period of communicability of the disease. The purpose of quarantine is to prevent effective contact with the general population.

(A) Complete quarantine is a limitation of freedom of movement of persons or animals exposed to a reportable disease, for a period of time not longer than the longest period of communicability of the disease, in order to prevent effective contact with the general population.

(B) Modified quarantine is a selective, partial limitation of freedom of movement of persons or animals determined on the basis of differences in susceptibility or danger of disease transmission. Modified quarantine is designed to meet particular situations and includes, but is not limited to, the exclusion of children from school, the closure of schools and places of public or private assembly and the prohibition or restriction of those exposed to a communicable disease from engaging in a particular occupation.

(35) Reportable disease is any disease or condition for which an official report is required. Any unusual expression of illness in a group of individuals which may be of public health concern is reportable and shall be reported to the local health department, local health authority or the Department of Health and Senior Services by the quickest means.

(36) Small quantity generator of infectious waste is any person generating one hundred kilograms (100 kg) or less of infectious waste per month and as regulated in 10 CSR 80.

(37) Terrorist event is the unlawful use of force or violence committed by a group or individual against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives. Terrorist attacks are classified as chemical, biological, or radiological.

(A) Chemical means any weapon that is designed or intended to cause widespread death or serious bodily injury through the release, dissemination, or impact of toxic or poisonous chemicals or precursors of toxic or poisonous chemicals.

(B) Biological means any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product.

(C) Radiological means any weapon that is designed to release radiation or radioactivity at a level dangerous to human life.

(38) Toxic substance is any substance, including any raw materials, intermediate products, catalysts, final products or by-products of any manufacturing operation conducted in a commercial establishment that has the capacity through its physical, chemical or biological properties to pose a substantial risk of death or impairment, either immediately or later, to the normal functions of humans, aquatic organisms or any other animal.

(39) Unusual diseases—Examples include, but are not limited to, the following:

(A) Diseases uncommon to a geographic area, age group, or anatomic site;

(B) Cases of violent illness resulting in respiratory failure;

(C) Absence of a competent natural vector for a disease; or

(D) Occurrence of hemorrhagic illness.

(40) Unusual manifestation of illness—Examples include, but are not limited to, the following:

(A) Multiple persons presenting with a similar clinical syndrome at a steady or increasing rate;

(B) Large numbers of rapidly fatal cases, with or without recognizable signs and symptoms;

(C) Two (2) or more persons, without a previous medical history, presenting with convulsions;

(D) Persons presenting with grayish colored tissue damage; or

(E) Adults under the age of fifty (50) years, without previous medical history, presenting with adult respiratory distress syndrome (ARDS).

(41) Varicella (Chickenpox) severity of illness shall include the following categories:

(A) Mild—less than fifty (50) lesions (able to count lesions within thirty (30) seconds);

(B) Moderate—fifty to five hundred (50–500) lesions (anything in between mild and severe); and

(C) Severe—more than five hundred (500) lesions (difficult to see the skin) or lesions with complications.

AUTHORITY: sections 192.006 and 260.203, RSMo 2000 and 192.020, RSMo Supp. 2005. This rule was previously filed as 13 CSR 50-101.010. Original rule filed July 15, 1948, effective Sept. 13, 1948. Rescinded and readopted: Filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Aug. 16, 1988, effective Dec. 29, 1988. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Amended: Filed June 1, 2000, effective Nov. 30, 2000. Amended: Filed Oct. 1, 2004, effective April 30, 2005. Amended: Filed Feb. 15, 2006, effective Sept. 30, 2006.*

**Original authority: 192.006.1, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951, 2004; and 260.203, RSMo 1986, amended 1988, 1992, 1993.*

19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases

PURPOSE: This rule designates the diseases, disabilities, conditions and findings that must be reported to the local health authority or the Department of Health and Senior Services. It also establishes when they must be reported.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The diseases within the immediately reportable disease category pose a risk to national security because they: can be easily disseminated or transmitted from person to person; result in high mortality rates and have the potential for major public health impact; might cause public panic and social disruption; and require special action for public health preparedness. Immediately reportable diseases or findings shall be reported to the local health authority or to the Department of Health and Senior Services immediately upon knowledge or suspicion by telephone (1 (800) 392-0272), facsimile or other rapid communication. Immediately reportable diseases or findings are—

(A) Selected high priority diseases, findings vent: or agents that occur naturally, from acci- dental exposure, or as the result of a bioter- rorism e

Anthrax
Botulism
Plague
Rabies (Human)
Ricin toxin
Severe Acute Respiratory syndrome-associated Coronavirus (SARS-CoV) Disease
Smallpox
Tularemia (pneumonic)
Viral hemorrhagic fevers (filoviruses (e.g., Ebola, Marburg) and arenaviruses (e.g., Lassa, Machupo))

(B) Instances, clusters, or outbreaks of unusual diseases or manifestations of illness and clusters or instances of unexplained deaths which appear to be a result of a terrorist act or the intentional or deliberate release of biological, chemical, radiological, or physical agents, including exposures through food, water, or air.

(C) Instances, clusters, or outbreaks of unusual, novel, and/or emerging diseases or findings not otherwise named in this rule, appearing to be naturally occurring, but posing a substantial risk to public health and/or social and economic stability due to their ease of dissemination or transmittal, associated mortality rates, or the need for special public health actions to control.

(2) Reportable within one (1) day diseases or findings shall be reported to the local health authority or to the Department of Health and Senior Services withinone (1) calendar day of first knowledge or suspicion by telephone, facsimile or other rapid communication. Reportable within one (1) day diseases or findings are—

(A) Diseases, findings or agents that occur naturally, or from accidental exposure, or as a result of an undetected bioterrorism event:

Acute respiratory distress syndrome (ARDS) in patients under fifty (50) years of age
Animal (mammal) bite, wound, humans
Brucellosis
Cholera
Dengue fever
Diphtheria
Glanders
Haemophilus influenzae, invasive disease
Hantavirus pulmonary syndrome
Hemolytic uremic syndrome (HUS), post-diarrheal
Hepatitis A
Influenza—associated public and/or private school closures
Lead (blood) level greater than or equal to forty-five micrograms per deciliter (≥45 µg/dl) in any person equal to or less than seventy-two (≤72) months of age
Measles (rubeola)
Meningococcal disease, invasive
Outbreaks (including nosocomial) or epidemics of any illness, disease or condition that may be of public health concern, including any illness in a food handler that is potentially transmissible through food
Pertussis
Poliomyelitis
Q fever
Rabies (animal)
Rubella, including congenital syndrome
Shiga toxin-producing *Escherichia coli* (STEC)
Shiga toxin positive, unknown organism
Shigellosis
Staphylococcal enterotoxin B

Streptococcus pneumoniae, drug resistant invasive disease
Syphilis, including congenital syphilis
T-2 mycotoxin
Tetanus
Tuberculosis disease Tularemia
(non-pneumonic) Typhoid fever
(Salmonella typhi)
Vancomycin-intermediate *Staphylococcus aureus* (VISA), and Vancomycin-resistant *Staphylococcus aureus* (VRSA)
Venezuelan equine encephalitis virus neuroinvasive disease
Venezuelan equine encephalitis virus non-neuroinvasive disease
Yellow fever

(B) Diseases, findings or adverse reactions that occur as a result of inoculation to prevent smallpox, including but not limited to the following:
Accidental administration
Contact transmission (i.e., vaccinia virus infection in a contact of a smallpox vaccinee)
Eczema vaccinatum
Erythema multiforme (roseola vaccinia, toxic urticaria)
Fetal vaccinia (congenital vaccinia)
Generalized vaccinia
Inadvertent autoinoculation (accidental implantation)
Myocarditits, pericarditis, or myopericarditis
Ocular vaccinia (can include keratitis, conjunctivitis, or blepharitis)
Post-vaccinial encephalitis or encephalamyelitis
Progressive vaccinia (vaccinia necrosum, vaccinia gangrenosa, disseminated vaccinia)
Pyogenic infection of the vaccination site
Stevens-Johnson Syndrome

(3) Reportable within three (3) days diseases or findings shall be reported to the local health authority or the Department of Health and Senior Services within three (3) calendar days of first knowledge or suspicion. These diseases or findings are—
Acquired immunodeficiency syndrome (AIDS)
Arsenic poisoning
Blastomycosis
California serogroup virus neuroinvasive disease
California serogroup virus non-neuroinvasive disease
Campylobacteriosis
Carbon monoxide poisoning
CD4+ T cell count
Chancroid
Chemical poisoning, acute, as defined in the most current ATSDR CERCLA Priority List of Hazardous Substances; if terrorism is suspected, refer to subsection (1)(B)
Chlamydia trachomatis, infections
Coccidioidomycosis
Creutzfeldt-Jakob disease
Cryptosporidiosis
Cyclosporiasis
Eastern equine encephalitis virus neuroinvasive disease
Eastern equine encephalitis virus non-neuroinvasive disease
Ehrlichiosis, human granulocytic, monocytic, or other/unspecified agent
Giardiasis
Gonorrhea
Hansen's disease (Leprosy)
Heavy metal poisoning including, but not limited to, cadmium and mercury
Hepatitis B, acute
Hepatitis B, chronic
Hepatitis B surface antigen (prenatal HBsAg) in pregnant women
Hepatitis B Virus Infection, perinatal (HBsAg positivity in any infant aged equal to or less than twenty-four (≤24) months who was born to an HBsAg-positive mother)
Hepatitis C, acute
Hepatitis C, chronic
Hepatitis non-A, non-B, non-C
Human immunodeficiency virus (HIV)-exposed newborn infant (i.e., newborn infant whose mother is infected with HIV)
Human immunodeficiency virus (HIV) infection, as indicated by HIV antibody testing (reactive screening test followed by a positive confirmatory test), HIV antigen testing (reactive screening test followed by a positive confirmatory test), detection of HIV nucleic acid (RNA or DNA), HIV viral culture, or other testing that indicates HIV infection
Human immunodeficiency virus (HIV) test results (including both positive and negative results) for children less than two (2) years of age whose mothers are infected with HIV
Human immunodeficiency virus (HIV) viral load measurement (including non-detectable results)
Hyperthermia
Hypothermia
Lead (blood) level less than forty-five micrograms per deciliter (<45 µg/dl) in any person equal to or less than seventy-two (≤72) months of age and any lead (blood) level in persons older than seventy-two (>72) months of age
Legionellosis
Leptospirosis
Listeriosis
Lyme disease
Malaria
Methemoglobinemia, environmentally-induced
Mumps
Mycobacterial disease other than tuberculosis (MOTT)
Occupational lung diseases including silicosis, asbestosis, byssinosis, farmer's lung and toxic organic dust syndrome
Pesticide poisoning
Powassan virus neuroinvasive disease
Powassan virus non-neuroinvasive disease
Psittacosis
Rabies Post-Exposure Prophylaxis (Initiated)
Respiratory diseases triggered by environmental contaminants including environmentally or occupationally induced asthma and bronchitis
Rocky Mountain spotted fever
Saint Louis encephalitis/virus neuroinvasive disease
Saint Louis encephalitis virus non-neuroinvasive disease
Salmonellosis
Streptococcal disease, invasive, Group A
Streptococcus pneumoniae, invasive in children less than five (5) years
Toxic shock syndrome, staphylococcal or streptococcal
Trichinellosis
Tuberculosis infection
Varicella (Chickenpox)
Varicella deaths
West Nile virus neuroinvasive disease
West Nile virus non-neuroinvasive disease
Western equine encephalitis virus neuroinvasive disease
Western equine encephalitis virus non-neuroinvasive disease
Yersiniosis

(4) Reportable weekly diseases or findings shall be reported directly to the Department of Health and Senior Services weekly. These diseases or findings are:
Influenza, laboratory-confirmed

(5) Reportable quarterly diseases or findings shall be reported directly to the Department of Health and Senior Services quarterly. These diseases or findings are:
Methicillin-resistant *Staphylococcus aureus* (MRSA), nosocomial
Vancomycin-resistant enterococci (VRE), nosocomial

(6) A physician, physician's assistant, nurse, hospital, clinic, or other private or public

institution providing diagnostic testing, screening or care to any person with any disease, condition or finding listed in sections (1)–(4) of this rule or who is suspected of having any of these diseases, conditions or findings, shall make a case report to the local health authority or the Department of Health and Senior Services, or cause a case report to be made by their designee, within the specified time.

(A) A physician, physician's assistant, or nurse providing care in an institution to any patient with any disease, condition or finding listed in sections (1)–(4) of this rule may authorize, in writing, the administrator or designee of the institution to submit case reports on patients attended by the physician, physician's assistant, or nurse at the institution. But under no other circumstances shall the physician, physician's assistant, or nurse be relieved of this reporting responsibility.

(B) Duplicate reporting of the same case by health care providers in the same institution is not required.

(7) Except for influenza, laboratory-confirmed and Varicella (Chickenpox); a case report as required in section (6) of this rule shall include the patient's name, home address with zip code, date of birth, age, sex, race, home phone number, name of disease, condition or finding diagnosed or suspected, the date of onset of the illness, name and address of the treating facility (if any) and the attending physician, any appropriate laboratory results, name and address of the reporter, treatment information for sexually transmitted diseases, and the date of report.

(A) A report of an outbreak or epidemic as required in subsections (1)(B) and (1)(C) of this rule shall include the diagnosis or principal symptoms, the approximate number of cases, the local health authority jurisdiction within which the cases occurred, the identity of any cases known to the reporter, and the name and address of the reporter.

(B) Influenza, laboratory-confirmed reporting as required in section (4) of this rule shall include the patient's age group (i.e., 0–4, 5–24, 25–64, and 65+ years) and serology/serotype (i.e., A, B, and unknown), the local health authority jurisdiction within which the cases occurred, and the date of report. Aggregate patient data shall be reported weekly.

(C) Varicella (Chickenpox) reporting as required in section (3) of this rule shall include the patient's name, date of birth, vaccination history, and severity of illness; the local health authority jurisdiction within which the cases occurred, and the date of report.

(8) Any person in charge of a public or private school, summer camp or child or adult care facility shall report to the local health authority or the Department of Health and Senior Services the presence or suspected presence of any diseases or findings listed in sections (1)–(4) of this rule according to the specified time frames.

(9) All local health authorities shall forward to the Department of Health and Senior Services reports of all diseases or findings listed in sections (1)–(4) of this rule. All reports shall be forwarded according to procedures established by the Department of Health and Senior Services director as listed in sections (1)–(4). Reports will be forwarded immediately if a terrorist event is suspected or confirmed. The local health authority shall retain from the original report any information necessary to carry out the required duties in 19 CSR 20-20.040(2) and (3).

(10) Information from patient medical records received by local public health agencies or the Department of Health and Senior Services in compliance with this rule is to be considered confidential records and not public records.

(11) Reporters specified in section (6) of this rule will not be held liable for reports made in good faith in compliance with this rule.

(12) The following material is incorporated into this rule by reference:

(A) 2005 Agency for Toxic Substances and Disease Registry (ATSDR) 1825 Century Blvd., Atlanta, GA 30345, Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) Priority List of Hazardous Substances, available at: http://www.atsdr.cdc.gov/cercla. This rule does not incorporate any subsequent amendments or additions.

(13) Each hospital and ambulatory surgical center shall report on a quarterly basis antibiogram data for infection, not colonization, from all body sites monitored by that health care facility. Antibiogram data to be reported shall include nosocomial methicillin sensitive *Staphylococcus aureus (S. aureus)*, nosocomial *S. aureus*, nosocomial vancomycin sensitive enterococci, and nosocomial enterococci isolates. Data shall be reported directly to the Department of Health and Senior Services. Reporting shall include only a patient's first diagnostic nosocomial isolate per admission of *Staphylococcus aureus (S. aureus)* and enterococci and the isolates corresponding methicillin or vancomycin sensitivity; irrespective of location or of other antimicrobial sensitivity(ies). Intermediate methicillin or vancomycin sensitivity shall be reported as resistant (i.e., methicillin-resistant *Staphylococcus aureus* (MRSA) or vancomycin-resistant enterococci (VRE), respectively).

(A) Isolates from cultures performed for routine surveillance purposes are excluded from the requirement to report. Methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci (VRE) nosocomial infections to be reported to the Department of Health and Senior Services are limited to those body sites monitored by the individual hospital or ambulatory surgical center.

(B) Aggregate antibiogram data for patients' non-duplicative isolates, per admission, of nosocomial MRSA and VRE infections shall reflect susceptibility patterns and shall be reported as the:

1. Number of nosocomial isolates of *S. aureus* sensitive to methicillin (oxacillin, etc.);
2. Number of nosocomial isolates *S. aureus*;
3. Number of nosocomial isolates of enterococci sensitive to vancomycin; and
4. Number of nosocomial isolates enterococci.

(C) Aggregate data shall be reported for the quarters January–March, April–June, July–September, and October–December within ten (10) days of the end of the quarter. Each quarter's aggregate report shall include only those data that are available within a ten (10)-day reporting period from the end of that quarter.

AUTHORITY: sections 192.006, 192.139, 210.040 and 210.050, RSMo 2000 and 192.020, RSMo Supp. 2005. This rule was previously filed as 13 CSR 50-101.020. Original rule filed July 15, 1948, effective Sept. 13, 1948. Amended: Filed Sept. 1, 1981, effective Dec. 11, 1981. Rescinded and readopted: Filed Nov. 23, 1982, effective March 11, 1983. Emergency amendment filed June 10, 1983, effective June 20, 1983, expired Sept. 10, 1983. Amended: Filed June 10, 1983, effective Sept. 11, 1983. Amended: Filed Nov. 4, 1985, effective March 24, 1986. Amended: Filed Aug. 4, 1986, effective Oct. 11, 1986. Amended: Filed June 3, 1987, effective Oct. 25, 1987. Emergency amendment filed June 16, 1989, effective June 26, 1989, expired Oct. 23, 1989. Amended: Filed July 18, 1989, effective Sept. 28, 1989. Amended: Filed Nov. 2, 1990, effective March 14, 1991. Emergency amendment filed Oct. 2, 1991, effective Oct. 12, 1991, expired Feb. 8, 1992. Amended: Filed Oct. 2, 1991,*

effective Feb. 6, 1992. Amended: Filed Jan. 31, 1992, effective June 25, 1992. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1994, effective March 30, 1995. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Amended: Filed June 1, 2000, effective Nov. 30, 2000. Emergency amendment filed Dec. 16, 2002, effective Dec. 26, 2002, expired June 23, 2003. Amended: Filed Dec. 16, 2002, effective June 30, 2003. Amended: Filed Oct. 1, 2004, effective April 30, 2005. Amended: Filed Feb. 15, 2006, effective Sept. 30, 2006.

**Original authority: 192.006.1, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951, 2004; 192.139, RSMo 1988; 210.040, RSMo 1941, amended 1993; and 210.050, RSMo 1941, amended 1993.*

19 CSR 20-20.030 Exclusion From School and Readmission

PURPOSE: This rule requires the exclusion of persons from school who have a reportable disease or who are liable to transmit a reportable disease. The methods of readmission to school are also established.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Persons suffering from a reportable disease or who are liable to transmit a reportable disease listed in 19 CSR 20-20.020(1)–(3) shall be barred from attending school.

(2) Any person excluded from school under section (1) of this rule may be readmitted to school by one (1) of the following methods:

(A) Certification in writing by an attending physician attesting to the person's noninfectiousness;

(B) After a period of time equal to the longest period of communicability of the disease as established in the 1990 fifteenth edition of the *Control of Communicable Diseases in Man* published by the American Public Health Association; the 1991 twenty-second edition of the *Report of the Committee on Infectious Diseases* published by the American Academy of Pediatrics; or the following recommendations of the Immunization Practices Advisory Committee published by the Centers for Disease Control in the *Morbidity and Mortality Weekly Report: General Recommendations on Immunization*, April 7, 1989; *Update on Adult Immunization*, November 15, 1991; *New Recommended Schedule for Active Immunization of Normal Infants and Children*, September 19, 1986; *Pertussis Vaccination: Acellular Pertussis Vaccine for Reinforcing and Booster Use—Supplementary ACIP Statement*, February 7, 1992; *Diphtheria, Tetanus and Pertussis: Recommendations for Vaccine Use and Other Preventive Measures*, August 8, 1991; *Haemophilus b Conjugate Vaccines for Prevention of Haemophilus influenza Type b Disease Among Infants and Children Two Months of Age and Older*, January 11, 1991; *Immunization of Children Infected With Human Immunodeficiency Virus—Supplementary ACIP Statement*, April 1, 1988; *Immunization of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus*, September 26, 1986; *Prevention and Control of Influenza*, May 15, 1992; *Measles Prevention: Recommendations of the Immunization Practices Advisory Committee (ACIP)*, December 29, 1989; *Meningococcal Vaccines*, May 10, 1985; *Mumps Prevention*, June 9, 1989; *Pneumococcal Polysaccharide Vaccine*, February 10, 1989; *Poliomyelitis Prevention: Enhanced-Potency Inactivated Poliomyelitis Vaccine Supplementary— Statement*, December 11, 1987; *Poliomyelitis Prevention*, January 29, 1982; *Rabies Prevention*, March 22, 1991; *Rubella Prevention*, November 23, 1990; *Varicella-Zoster Immune Globulin for the Prevention of Chickenpox*, February 24, 1984; *Hepatitis B Virus: A Comprehensive Strategy for Eliminating Transmission in the United States Through Universal Childhood Vaccination*, November 22, 1991; *Plague Vaccine*, June 11, 1982; *Typhoid Immunization*, July 13, 1990; *Typhus Vaccine*, June 2, 1978; and *Yellow Fever Vaccine*, May 4, 1990; or

(C) When the local health authority declares that the designated health emergency is ended, after consultation and concurrence of the director of the Department of Health or his/her designated representative.

AUTHORITY: sections 192.005.2. and 192.020, RSMo 1994. This rule was previously filed as 13 CSR 50-101.041. Original rule filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Sept. 16, 1982, effective Jan. 14, 1983. Amended: Filed Aug. 4, 1986, effective Oct. 11, 1986. Amended: Filed April 4, 1988, effective June 27, 1988. Emergency amendment filed Jan. 13, 1989, effective Jan. 23, 1989, expired May 22, 1989. Amended: Filed Jan. 13, 1989, effective May 11, 1989. Amended: Filed Oct. 3, 1989, effective Feb. 25, 1990. Amended: Filed Nov. 2, 1990, effective March 14, 1991. Amended: Filed July 12, 1991, effective Oct. 31, 1991. Amended: Filed Aug. 14, 1992, effective Feb. 26, 1993.*

**Original authority: 192.005.2., RSMo 1985, amended 1993 and 192.020, RSMo 1939, amended 1945, 1951.*

19 CSR 20-20.040 Measures for the Control of Communicable, Environmental and Occupational Diseases

PURPOSE: This rule defines investigative and control measures for reportable diseases and establishes who is responsible for them.

Editor's Note: The following material is incorporated into this rule by reference:

1) Morbidity and Mortality Weekly Report (Atlanta: Centers for Disease Control).

In accordance with section 536.031(4), RSMo, the full text of material incorporated by reference will be made available to any interested person at the Office of the Secretary of State and the headquarters of the adopting state agency.

(1) In controlling the diseases and findings listed in 19 CSR 20-20.020, the director shall comply with the methods of control section of one (1) of the two (2) books listed in 19 CSR 20-20.030(2)(B) or the recommendations of the Immunization Practices Advisory Committee (ACIP) published by the Centers for Disease Control in the *Morbidity and Mortality Weekly Report* listed in 19 CSR 20-20.030(2)(B). The director shall use the legal means necessary to control, investigate, or both, any disease or condition listed in 19 CSR 20-20.020 which is a threat to the public health.

(2) It shall be the duty of the local health authority, the director of the Department of Health or the director's designated representative on receiving a report of a communicable, environmental or occupational disease to—

(A) Inspect any premises that they have reasonable grounds to believe are in a condition conducive to the spread of any communicable disease;

(B) Confer with the physician, laboratory or person making the report;

(C) Collect for laboratory analysis any samples or specimens that may be necessary to confirm the diagnosis or presence of the disease or biological, chemical or physical

agents and to determine the source of the infection, epidemic or exposure. Health program representatives and other personnel employed by the Department of Health, after training and certification to perform venipuncture, and after specific authorization from a physician, are authorized to perform venipuncture utilizing procedures within the scope of the training they have been given. The content and scope of this training shall be established by the Department of Health. Training shall be provided by a physician or his/her designee and the certificate shall be signed by the physician. Nothing in this rule shall limit the authority of local public health departments to establish their own training policies, with or without certification, or to limit their voluntary participation in the certification program developed by the Department of Health, nor shall it apply to venipuncture for other purposes;

(D) Make a complete epidemiological, environmental or occupational industrial hygiene investigation and record of the findings on a communicable disease or exposure report form;

(E) Establish and maintain quarantine, isolation or other measures as required;

(F) Provide the opportunity to be immunized to all contacts of persons suffering from those diseases for which there is a reliable and approved means of immunization;

(G) Establish appropriate control measures which may include isolation, quarantine, disinfection, immunization, closure of establishment and other measures considered appropriate by medical experts for the protection of public health;

(H) Establish, as the local health authority, whenever a case of unrecognized illness is reported or otherwise brought to the attention of the local health authority or the Department of Health and investigation presents symptoms of a communicable disease, but sufficient time has not elapsed to render a positive diagnosis, after consultation with the director or his/her designated representative, the control measures applicable in actual cases of the suspected communicable disease, until a positive diagnosis can be established. If a disease proves to be noncommunicable, the temporary control measures shall be terminated at once;

(I) Assume direct responsibility as director of health to make necessary investigation and immediately institute appropriate control measures necessary for the protection of the public health in occurrence of outbreaks or unusual clusters of illness involving more than one (1) county or a general regional area; and

(J) Investigate, as the local health authority, the disease within the local jurisdiction with assistance from the director of the Department of Health or his/her designated representative when any outbreak or unusual occurrence of a reportable disease is identified through reports required by 19 CSR 20-20.020. If, in the judgment of the director, the disease outbreak or unusual occurrence constitutes a medical emergency, the director may assume direct responsibility for the investigation.

(3) It shall be the duty of the local health authority, upon identification of a case of a reportable disease or upon receipt of a report of that disease, to take actions and measures as may be necessary according to any policies which have been or may be established by the director of the Department of Health, within the provisions of section (2) and subsections (2)(A)–(J) of this rule.

(A) When the local health authority is notified of a reportable disease or has reason to suspect the existence of a reportable disease within the local jurisdiction, the local health authority, either in person or through a designated representative, shall make an investigation as is necessary and immediately institute appropriate control measures as set forth in section (2) and subsections (2)(A)–(J) of this rule.

(B) The local health authority shall use every reasonable means to determine the presence of a communicable disease or the source of any disease listed in 19 CSR 20-20.020 or of any epidemic disease of unknown cause. In the performance of this duty, the local health authority shall examine or cause to be examined any person reasonably suspected of being infected or of being a source or contact of infection and any person who refuses examination shall be quarantined or isolated.

(C) Control measures implemented by the local health authority shall be at least as stringent as those established by the director of the Department of Health and shall be subject to review and alteration by the director. If the local health authority fails to carry out appropriate control measures, the director or his/her designated representative shall take steps necessary to protect the public health.

(4) It shall be the duty of the attending physician, immediately upon diagnosing a case of a reportable communicable disease, to give detailed instructions to the patient, members of the household and attendants regarding proper control measures. When a person dies while infected with a communicable disease, it shall be the duty of the attending physician to learn immediately who is to prepare the body for burial or cremation and then notify the funeral director, embalmer or other responsible person regarding the communicable disease the deceased had at the time of death. A tag shall also be affixed to the body providing the name of the communicable disease likely to have been present at the time of death.

(5) Every practitioner of the healing arts and every person in charge of any medical care facility shall permit the director of the Department of Health or the director's designated representative to examine and review any medical records which are in the practitioner's or person's possession or to which the practitioner or person has access, upon request of the director or the director's designated representative in the course of investigation of reportable diseases in 19 CSR 20-20.020.

AUTHORITY: sections 192.006 and 192.020, RSMo 2000. This rule was previously filed as 13 CSR 50-101.050. Original rule filed July 15, 1948, effective Sept. 13, 1948. Rescinded and readopted: Filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Sept. 16, 1982, effective Jan. 14, 1983. Amended: Filed March 21, 1984, effective July 15, 1984. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Amended: Filed Nov. 15, 1989, effective Feb. 11, 1990. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency amendment filed June 13, 2002, effective July 1, 2002, expires Dec. 27, 2002. Amended: Filed June 13, 2002, effective Nov. 30, 2002.*

**Original authority: 192.006.1., RSMo 1993, amended 1995 and 192.020, RSMo 1939, amended 1945, 1951.*

19 CSR 20-20.050 Quarantine or Isolation Practices and Closing of Schools and Places of Public and Private Assembly

PURPOSE: This rule provides for the isolation or quarantine of persons and animals with a communicable disease and their contacts; it also authorizes the closing of schools and places of public and private assembly.

(1) The local health authority, the director of the Department of Health or the director's designated representative shall require isolation of a patient or animal with a communicable disease, quarantine of contacts, concurrent and terminal disinfection, or modified forms of these procedures necessary for the protection of the public health. The isolation

of a patient, animal or contact shall be carried out according to the methods of control in 19 CSR 20-20.040(1).

(2) No person or animal infected with or suspected of having a communicable disease listed in 19 CSR 20-20.020(1)–(3) or any contact of a disease subject to quarantine or isolation shall move or be moved from one (1) health jurisdiction to another, unless necessary for medical care, without notice to and consent from the local health authority, the director of the Department of Health or the director's designated representative. If a person is moved for the reason of medical care, the health authority who ordered the isolation or quarantine shall be notified within seventy-two (72) hours.

(3) The local health authority, the director of the Department of Health or the director's designated representative is empowered to close any public or private school or other place of public or private assembly when, in the opinion of the local health authority, the director of the Department of Health or the director's designated representative, the closing is necessary to protect the public health. Any school or other place of public or private assembly that is ordered closed shall not reopen until permitted by whomever ordered the closure.

AUTHORITY: section 192.020, RSMo 1994. This rule was previously filed as 13 CSR 50-101.061. Original rule filed Dec. 11, 1981, effective May 13, 1982.*

**Original authority: 192.020, RSMo 1939, amended 1945, 1951.*

19 CSR 20-20.060 Control Measures for Food Handlers

PURPOSE: This rule establishes control measures for persons working with food products who are suspected of having a communicable disease.

(1) For the purpose of this rule, a communicable disease is defined as a disease transmitted through handling food.

(2) No person infected with a communicable disease, whether actively infected or a chronic carrier, and no person with any one (1) of the signs and symptoms listed in this section, shall engage in the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food. The following signs and symptoms indicate infection with a foodborne pathogen: diarrhea, vomiting, open skin sores, boils, fever, dark urine or jaundice, unless determined not to be caused by a pathogen able to be transmitted by food. The local health authority, the director of the Department of Health or the director's designated representative may order examinations necessary to determine the presence of a foodborne infection.

(3) Notice shall be sent immediately to the local health authority, to the director of the Department of Health or to the director's designated representative by any person responsible for the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food if any infection or disease known to be transmissible through food occurs on the premises or among the employees.

(4) When the possibility of transmission of infection is suspected in any person engaged in the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food; the local health authority, the director of the Department of Health or the director's designated representative is authorized to require any of the following measures:

(A) The immediate exclusion of that person from the production, preparation, manufacture, packaging, storage, sale, distribution or transportation of food;

(B) The immediate exclusion of the food supply concerned from distribution and use; and

(C) Adequate medical examination of that person and his/her associates, including necessary laboratory testing of blood, feces, sputum, throat cultures and other bodily secretions or excreta.

AUTHORITY: sections 192.005.2., 192.020, 196.045 and 196.225, RSMo 1994. This rule was previously filed as 13 CSR 50-101.071. Original rule filed Dec. 11, 1981, effective May 13, 1982. Amended: Filed Nov. 4, 1992, effective May 6, 1993.*

**Original authority: 192.005.2., RSMo 1985, amended 1993; 192.020, RSMo 1939, amended 1945, 1951; 196.045, RSMo 1943, amended 1993; and 196.225, RSMo 1939, amended 1977.*

19 CSR 20-20.070 Duties of Local Health Departments

PURPOSE: This rule establishes procedures for reporting communicable diseases to the Missouri Department of Health by local health departments.

(1) All local health authorities shall forward reports of all diseases and conditions mentioned in 19 CSR 20-20.020 to the Missouri Department of Health. These reports shall be forwarded within twenty-four (24) hours after they are received, according to procedures established by the Department of Health director. Local health authorities shall transcribe from the original reports information necessary to the conduct of their duties in 19 CSR 20-20.040(2), (2)(A)–(J), (3) and (3)(A)–(C) before forwarding the reports. All reports received by either the local health authority or the Department of Health are to be considered confidential records and not public records.

AUTHORITY: section 192.020, RSMo 1994. This rule was previously filed as 13 CSR 50-101.080. Original rule filed July 15, 1948, effective Sept. 13, 1948. Amended: Filed Dec. 11, 1981, effective May 13, 1982.*

**Original authority: 192.020, RSMo 1939, amended 1945, 1951.*

19 CSR 20-20.075 Confidentiality of Information Obtained for Reporting of Communicable, Environmental and Occupational Diseases and Conditions

PURPOSE: This rule requires local public health agencies to establish confidentiality policies and procedures which are as stringent as Missouri Department of Health (MDOH) policies and procedures for information obtained for reporting of communicable, environmental and occupational diseases. It also requires establishment of security policies and procedures for access to MDOH information systems.

(1) Local public health agencies shall adopt and abide by confidentiality policies and procedures which are as stringent as Missouri Department of Health (MDOH) policies and procedures for information obtained for the reporting of communicable, environmental and occupational diseases defined in 19 CSR 20-20.020.

(2) Such information may be used only for investigation to determine the source of exposure and/or potential for spread; follow-up screening to monitor disease, exposure status, or communicability; counseling and patient education regarding the disease or condition and its prevention; administration of immunizations and/or prophylactic medications to the case or contacts; isolation and/or restriction of the client's or contact's activities; environmental assessment and other activities

undertaken to eliminate the source of exposure; or epidemiologic analysis to determine trends in incidence, prevalence, treatment, disease progression, and/or risk factors associated with diseases.

(3) Local public health agencies shall forward reports to MDOH in accordance with 19 CSR 20-20.020. Otherwise, such information shall be released only in a statistical aggregate form that precludes and prevents the identification of an individual, physician, or medical facility except when such release is specifically authorized by law.

(4) Local public health agencies that access MDOH information systems shall establish security policies and procedures which are as stringent as MDOH policies and procedures to protect information systems against unauthorized data disclosure, modification, or destruction and to protect the integrity of the information system. Local public health agencies and employees who use MDOH information systems to perform their duties shall abide by MDOH policies and procedures for access to and use of information systems.

(5) Local public health agencies shall provide comprehensive training to employees on confidentiality and security policies, laws, and the administrative, civil, and criminal penalties for violations. Local public health agencies shall monitor employees to assure compliance with confidentiality laws, rules, policies and procedures. Local public health agencies shall immediately report to MDOH any breaches of confidentiality and security as specified by MDOH policy.

(6) Contractors performing work for MDOH or local public health agencies that involves access to information obtained for the reporting of communicable, environmental and occupational diseases shall be required, through their contracts, to abide by sections (1)–(5) of this rule.

AUTHORITY: sections 191.656, 192.006, 701.328, RSMo Supp. 1998 and 167.183, 192.020, 192.067 and 192.802, RSMo 1994. Original rule filed Aug. 4, 1999, effective Jan. 30, 2000.*

**Original authority: 167.183, RSMo 1992; 191.656, RSMo 1988, amended 1992, 1993, 1996; 192.006, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951; 192.067, RSMo 1988; 192.802, RSMo 1992; and 701.328, RSMo 1993, amended 1998.*

19 CSR 20-20.080 Duties of Laboratories

PURPOSE: This rule establishes the responsibility of laboratories to report to the Missouri Department of Health and Senior Services specified results of tests and to submit isolates/specimens for certain diseases and conditions.

(1) The director, person in charge of any laboratory, or designee of the director or person in charge of any laboratory shall report to the local health authority or the Missouri Department of Health and Senior Services the result of any test that is positive for, or suggestive of, any disease or condition listed in 19 CSR 20-20.020. These reports shall be made according to the time and manner specified for each disease or condition following completion of the test and shall designate the test performed, all results of the test, including numeric results, if applicable, units of measure of the results, and reference ranges for normal and abnormal results, the name and address of the attending physician, the name of the disease or condition diagnosed or suspected, the date the test results were obtained, the name and home address (with zip code) of the patient and the patient's age, date of birth, sex, race, and ethnicity.

(2) In reporting findings for diseases or conditions listed in 19 CSR 20-20.020, laboratories shall report—

Arsenic—results of all biological specimens including time frame of urine specimen collection, if applicable;

Cadmium—results of all biological specimens including time frame of urine specimen collection, if applicable;

Carboxyhemoglobin proportion—all results;

Chemical/pesticide (blood or serum)—all results, including if none detected;

Lead level—results of all biological specimens;

Mercury—results of all biological specimens including time frame of urine specimen collection, if applicable; and

Methemoglobin proportion—all results.

(3) Isolates or specimens positive for the following reportable diseases or conditions must be submitted to the State Public Health Laboratory for epidemiological or confirmation purposes:

Anthrax (*Bacillus anthracis*)

Campylobacter species

Cholera (*Vibrio cholerae*)

Diphtheria (*Corynebacterium diphtheriae*)

Escherichia coli O157:H7

Haemophilus influenzae, invasive disease

Influenza Virus-associated pediatric mortality

Malaria (*Plasmodium* species)

Measles (rubeola)

Mycobacterium tuberculosis

Neisseria meningitidis, invasive disease

Orthopoxvirus (smallpox/cowpox-vaccinia/monkeypox)

Other Shiga Toxin positive organisms

Pertussis (*Bordetella pertussis*)

Plague (*Yersinia pestis*)

Salmonella species

Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease

Shigella species

Tularemia, pneumonic

Vancomycin-intermediate *Staphylococcus aureus* (VISA)

Vancomycin Resistant *Staphylococcus aureus*

(4) Every laboratory performing culture and sensitivity testing on human specimens in Missouri for health care facilities shall annually report these results to the Missouri Department of Health and Senior Services (MDHSS) for each facility provided this service. The data submitted should be in the format of antibiograms as defined by the Clinical and Laboratory Standards Institute (CLSI), M39-A2, Analysis and Presentation of Cumulative Antimicrobial Susceptibility Test Data. Only data from the first unique isolate from each patient should be included. Duplicate cultures must be excluded when compiling these antibiograms. The antibiograms for the preceding year are to be sent to MDHSS by July 1 of the following year (ex: 2006 data, January 1, 2006–December 31, 2006, will be due on July 1, 2007).

AUTHORITY: sections 192.006, RSMo 2000 and 192.020 and 192.131 RSMo Supp. 2005. This rule was previously filed as 13 CSR 50-101.090. Original rule filed July 15, 1948, effective Sept. 13, 1948. Amended: Filed Aug. 4, 1986, effective Oct. 11, 1986. Amended: Filed Aug. 14, 1992, effective April 8, 1993. Amended: Filed Sept. 15, 1995, effective April 30, 1996. Emergency rule filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Emergency rescission filed June 2, 2000, effective June 15, 2000, expired Dec. 11, 2000. Previous version of rule rescinded filed June 1, 2000, effective Jan. 30, 2001. Readopted: Filed June 1, 2000, effective Nov. 30, 2000. Amended: March 14, 2003, effective Sept. 30, 2003. Amended: Filed March 14, 2003, effective Sept. 30, 2003. Amended: Filed April 15, 2005, effective Oct. 30, 2005.*

Amended: Filed Feb. 15, 2006, effective Sept. 30, 2006.

**Original authority: 192.006, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951, 2004; and 192.131, RSMo 1988, amended 2004.*

19 CSR 20-20.090 Contact With Communicable Diseases by First Responders or Emergency Medical Person and Mortuary Personnel

PURPOSE: This rule defines the procedures for notification to a first responder or emergency medical person and mortuary personnel who are exposed to an individual who is human immunodeficiency virus seropositive, hepatitis B infected or infected with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5).

(1) The following definitions shall be used in administering this rule:

(A) Authorized personnel—any individual who has the authority to hire or fire and demote or promote employees for a corporation, entity or organization;

(B) Emergency medical person—a licensed attendant who has been specially trained in emergency cardiac and noncardiac care, and who has successfully completed an emergency service training program certified by the Department of Health as meeting the requirements of sections 190.100–190.190, RSMo and any individual providing emergency medical services who is licensed under Chapters 334 and 335, RSMo;

(C) Employee—a wage earner or volunteer providing emergency care;

(D) Employer—one who provides gainful work for wage earners and volunteers in the emergency care area;

(E) Exposure—any contact with an individual who is human immunodeficiency virus (HIV) seropositive or infected with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5), when the contact is consistent with the known means of transmission and occurs within the period of communicability of the disease;

(F) Facility—a facility licensed under Chapter 197 or 198, RSMo.

(G) First responder—an individual with training in first aid or emergency medical care, who is associated with a police department, sheriff's department, fire service or ambulance service and who is routinely dispatched to the scene of an accident or unforeseen emergency medical incident prior to or with the arrival of a licensed, staffed and equipped ambulance;

(H) Mortuary personnel—those persons having direct contact with a corpse prior to completion of embalming, cremating or enclosing the corpse in a sealed casket; and

(I) To notify—within forty-eight (48) hours after confirming potential exposure, the facility shall report the potential exposure by phone or in person to the employer(s)/funeral director of the potentially exposed employee(s)/mortuary personnel.

(2) If a facility admits a patient who was in an emergency rescue operation, received medical treatment or was transported to the facility by a first responder or an emergency medical person and is subsequently diagnosed as HIV seropositive or infected with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5), the facility, after confirming the presence of the disease, shall notify the employer(s) of the potentially exposed employee(s). The employer(s) shall be provided with the ambulance run number, police incident report or sufficient information to enable identification of the potentially exposed employee without reference to the patient's name. Notifications shall remain confidential and shall be released to authorized personnel only.

(3) If mortuary personnel remove a corpse from a facility or provide care to the corpse and the facility subsequently determines the presence at the time of death of HIV seropositivity or infection with any other reportable communicable disease as listed in 19 CSR 20-20.020(1)–(5), the facility shall notify the funeral director of the mortuary personnel's contact.

(4) The employer/funeral director shall investigate the potential exposure of the employee/mortuary personnel to determine if it was consistent with the known means of transmission and occurred within the period of communicability of the disease in question.

(A) If the exposure was consistent with the known means of transmission and occurred within the period of communicability, the employer/funeral director shall notify the employee/mortuary personnel within forty-eight (48) hours.

(B) The employer/funeral director shall instruct the employee/mortuary personnel to contact the facility for medical direction.

AUTHORITY: sections 190.100–190.190 and 191.653, RSMo 1994. Original rule filed July 18, 1989, effective Nov. 11, 1989.*

**Original authority: 190.100, RSMo 1973, amended 1987, 1989; 190.105–190.115, RSMo 1973; 190.120, RSMo 1973, amended 1980; 190.125–190.135, RSMo 1973; 190.140, RSMo 1973, amended 1987; 190.141, RSMo 1989; 190.145, RSMo 1973, amended 1975; 190.150–190.160, RSMo 1973; 190.165, RSMo 1973, amended 1978; 190.171, RSMo 1978; 190.175–190.180, RSMo 1973; 190.185, RSMo 1973, amended 1989, 1993; 190.190, RSMo 1973; and 191.653, RSMo 1988.*

19 CSR 20-20.091 Testing for Contagious or Infectious Disease

PURPOSE: This rule determines the contagious or infectious diseases for which testing is reasonable and appropriate and which may be administered pursuant to section 191.631, RSMo.

(1) Tests for the following contagious or infectious diseases may be administered pursuant to sections 191.630 to 191.631, RSMo:

(A) Hepatitis B;

(B) Hepatitis C;

(C) Syphilis; and/or

(D) Human T-Cell Lymphotropic Virus (HTLV) I/II.

AUTHORITY: section 191.631, RSMo Supp. 2002. Original rule filed March 14, 2003, effective Sept. 30, 2003.*

**Original authority: 191.631, RSMo 2002.*

19 CSR 20-20.092 Blood-Borne Pathogen Standard Required for Occupational Exposure of Public Employees to Blood and Other Infectious Materials

PURPOSE: This rule establishes standards for protection of public employees from occupational exposure to blood-borne pathogens in the workplace.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) The blood-borne pathogen standard governing public employers in the state of Missouri having employees with occupational

exposure to blood or other potentially infectious materials shall be the standard of the Occupational Safety and Health Administration as codified in 29 CFR 1910.1030. The Occupational Safety and Health Administration standard as codified in 29 CFR 1910.1030 is incorporated herein by reference.

(2) As part of the Occupational Safety and Health Administration blood-borne pathogen standard codified in 29 CFR 1910.1030, each public employer having employees with occupational exposure is required to establish a written Exposure Control Plan. Such plan shall include a requirement that the most effective available needleless systems and sharps with engineered sharps injury protection be included as engineering and work practice controls. However, such engineering controls shall not be required if:

(A) None are available in the marketplace; or

(B) An evaluation committee, as described in section 191.640.5, RSMo determines by means of objective product evaluation criteria that use of such devices will jeopardize patient or employee safety with regard to a specific medical procedure.

AUTHORITY: sections 191.640, RSMo Supp. 2002 and 192.006, RSMo 2000. Original rule filed March 14, 2003, effective Sept. 30, 2003.*

**Original authority: 191.640, RSMo 2001; 192.006, RSMo 1993, amended 1995.*

19 CSR 20-20.100 Tuberculosis Testing for Residents and Workers in Long-Term Care Facilities and State Correctional Centers

PURPOSE: This rule establishes tuberculosis testing requirements for residents and workers in long-term care facilities and state correctional centers.

(1) General Requirements. Long-term care facilities and state correctional centers shall screen their residents and staff for tuberculosis using the Mantoux method purified protein derivative (PPD) five tuberculin unit (5 TU) test. Each facility shall be responsible for ensuring that all test results are completed and that documentation is maintained for all residents, employees, and volunteers.

(A) In interpreting this rule, long-term care facilities shall include employees, volunteers, and residents of residential care facilities I, residential care facilities II, intermediate care facilities and skilled nursing facilities as defined in section 198.006, RSMo.

(B) In interpreting this rule, state correctional centers shall include all employees and volunteers of the Missouri Department of Corrections and the residents of all correctional institutions operated by the Missouri Department of Corrections.

(C) Whenever tuberculosis is suspected or confirmed, or tuberculosis infection is diagnosed among residents, employees or volunteers, the Department of Health or local health authority shall be notified as required in 19 CSR 20-20.020(2).

(2) Long-Term Care Residents. Within one (1) month prior to or one (1) week after admission, all residents new to long-term care are required to have the initial test of a Mantoux PPD two (2)-step tuberculin test. If the initial test is negative, zero to nine millimeters (0–9 mm), the second test, which can be given after admission, should be given one to three (1–3) weeks later. Documentation of chest X ray evidence ruling out tuberculosis disease within one (1) month prior to admission, along with an evaluation to rule out signs and symptoms compatible with infectious tuberculosis, may be accepted by the facility on an interim basis until the Mantoux PPD two (2)-step test is completed.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) Bacillus of Calmette and Guerin (BCG) vaccination shall not prevent residents from receiving a tuberculin test.

(C) A reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis* for an individual with a history of BCG vaccination.

(D) Evidence of tuberculosis infection is considered to be a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X-ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Residents with a negative, zero to nine millimeters (0–9 mm), Mantoux PPD two (2)-step test need not be routinely retested unless exposed to infectious tuberculosis or they develop signs and symptoms which are compatible with tuberculosis disease.

(F) Residents with a documented history of tuberculosis infection or an adequate course of preventive treatment shall not be required to be retested. Residents with a documented history of tuberculosis disease and adequate chemotherapy shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All skin test results of five millimeters (5 mm) or more for contacts to infectious tuberculosis or for an individual who is immunocompromised, or ten millimeters (10 mm) or more for all others, shall require a chest X ray within one (1) week, or a review of the results of a chest X ray taken within the month prior to admission along with an evaluation to rule out signs and symptoms compatible with tuberculosis disease to rule out active pulmonary disease.

(H) Individuals with a positive finding presenting evidence of a recent, within one (1) month of the date of admission, chest X ray need not be given a new X ray. However, the results of the X ray must be reviewed in the light of the additional information of the identification of tuberculosis infection as indicated by the Mantoux PPD skin test.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive treatment and those for whom preventive treatment is not medically indicated need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All residents of long-term care facilities who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All long-term care facility residents shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(3) Long-Term Care Employees and Volunteers. All new long-term care facility employees and volunteers who work ten (10) or more hours per week are required to obtain a Mantoux PPD two (2)-step tuberculin test within one (1) month prior to starting employment in the facility. If the initial test is zero to nine millimeters (0–9 mm), the second test should be given as soon as possible within three (3) weeks after employment begins, unless documentation is provided indicating a Mantoux PPD test in the past and at least one (1) subsequent annual test within the past two (2) years. It is the responsibility of each facility to maintain a documentation of each employee's and volunteer's tuberculin status.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) BCG vaccination shall not prevent employees and volunteers from receiving a tuberculin test.

(C) For an individual with a history of BCG vaccination, a reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis*.

(D) Evidence of tuberculosis infection is considered to be a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Employees and volunteers with an initial zero to nine millimeters (0–9 mm) Mantoux PPD two (2)-step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record.

(F) Employees and volunteers with a documented history of a positive Mantoux PPD test shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All positive findings shall require a chest X ray to rule out active pulmonary disease.

(H) Individuals with a positive finding need not have repeat annual chest X rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive medication need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All employees and volunteers of long-term care facilities who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All employees or volunteers of these facilities shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(4) State Correctional Centers Residents. All residents of state correctional centers are required to obtain a Mantoux PPD two (2)-step tuberculin test upon admission to rule out tuberculosis. If the initial test is negative, zero to nine millimeters (0–9 mm), the second test should be given within ninety (90) days of entrance into the state correctional system.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) BCG vaccination shall not prevent residents from receiving a tuberculin test.

(C) For an individual with a history of BCG vaccination, a reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis*.

(D) A positive test is defined as having a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Individuals with an initial negative zero to nine millimeters (0–9 mm) Mantoux PPD two (2)-step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record.

(F) Individuals with a documented history of a positive Mantoux PPD test shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All positive findings shall require a chest X ray to rule out active pulmonary disease.

(H) Individuals with a positive finding need not have repeat annual chest X rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive medication need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All residents of state correctional centers who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All residents shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(5) Missouri Department of Corrections New Employees and Volunteers. All new employees and volunteers who work ten (10) or more hours per week for the Missouri Department of Corrections are required to obtain a Mantoux PPD two (2)-step tuberculin test within three (3) weeks of starting employment. If the initial test is negative, zero to nine millimeters (0–9 mm), the second test should be given one to three (1–3) weeks after the initial test. It is the responsibility of each state correctional center to maintain documentation of each employee's or volunteer's tuberculin status.

(A) All skin test results are to be documented in millimeters (mm) of induration.

(B) BCG vaccination shall not prevent new employees and volunteers from receiving a tuberculin test.

(C) For an individual with a history of BCG vaccination, a significant reaction of ten millimeters (10 mm) or more shall be considered as infected with *Mycobacterium tuberculosis*.

(D) A positive test is defined as having a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest X ray findings consistent with old healed tuberculosis disease, and ten millimeters (10 mm) or more for all others.

(E) Employees and volunteers with a negative zero to nine millimeters (0–9 mm) Mantoux PPD two (2)-step test shall be one (1)-step tuberculin tested annually and the results recorded in a permanent record.

(F) Employees and volunteers with a documented history of a positive Mantoux PPD test shall not be required to be retested. In the absence of documentation, a repeat test shall be required.

(G) All positive findings shall require a chest X ray to rule out active pulmonary disease.

(H) Individuals with a positive finding need not have repeat annual chest X rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

(I) An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive medication need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

(J) All employees and volunteers of state correctional centers who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All employees and volunteers shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

AUTHORITY: section 199.350, RSMo 1994. Original rule filed April 17, 1995, effective Nov. 30, 1995. Emergency amendment filed June 14, 2000, effective June 24, 2000, expired Feb. 22, 2001. Amended: Filed June 14, 2000, effective Nov. 30, 2000.*

**Original authority: 199.350, RSMo 199*

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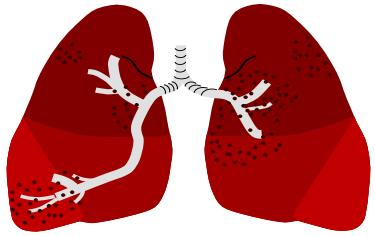

FOR
OFFICERS OF THE COURT
AND
TRANSPORTERS

WHAT IS TUBERCULOSIS?

TUBERCULOSIS
FACT SHEET

Missouri Department of Health and Senior Services
Tuberculosis Case Management Manual

Tuberculosis (TB) is a serious disease caused by a type of bacteria called mycobacterium tuberculosis.
TB usually attacks the lungs, but may cause disease in any part of the body. TB disease is the leading cause of death in the world.

IF I AM AROUND SOME ONE WITH TB, WILL I CATCH IT?

Usually, a person needs to spend a lot of time with a TB patient before they become infected. People that live in the same house or work with the person daily are the most at risk. Spending a few hours with a person is usually not enough to catch TB.

HOW DO YOU GET TB?

TB is spread through the air from one person to another. The bacteria gets into the air when a person with TB disease of the lungs or throat coughs, sneezes, talks or sings. People nearby may breath in these bacteria and become infected. TB is **NOT** spread by dishes, drinking glasses, clothing or touching a person with the disease.

HOW CAN I PROTECT MYSELF?

There are special masks (N-95) that you can wear when you are around a TB patient. These masks block the germs in the air so you can't breathe them into your lungs. These masks filter the air before you inhale it. If you are wearing your masks, the TB patient does not need to wear their masks.

CAN A TB PATIENT SAFELY BE IN A COURTROOM?

If the TB patient is wearing a surgical mask at all times, they should not be able to transmit TB. Since TB is spread only through the air, if masks are worn – it will be enough protection.

SHOULD THE TB PATIENT WEAR A MASK?

If a person has TB they should wear a regular surgical mask. This keeps the TB germs from entering the air. If a TB patient is wearing their mask, people around them do not need to wear the surgical mask.

WHAT SHOULD I DO IF I AM IN THE CAR WITH A TB PATIENT?

Either you or the TB patient should wear your mask at all times. Since TB is spread only through the air, if masks are worn – it will be enough protection.

HOW LONG IS SOMEONE WITH TB CONTAGIOUS?

A person with TB disease is contagious from the time he or she becomes ill until their sputum does not test positive. The person is not considered cured until a full course of medications have been completed, which is usually at least 6 months.

WHAT ACTIVITIES CAN SOMEONE WITH TB PARTICIPATE IN?

When the person is still contagious he should stay out of crowds, and wear a mask when out in public. If someone visits with a person with TB disease they should wear an appropriate mask. **Once the person is no longer contagious he may return to all normal activities.**